Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3907AGZ	A. BUILDING _____ B. WING _____	C 07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKER BASKET	3020 BEAUFORT CT N LAS VEGAS, NV 89032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 1 This Regulation is not met as evidenced by: Based on interview and record review on 7/14/10 and 7/15/10, the facility failed to ensure 4 of 6 residents, who received medications, had all of their prescribed medications available in the facility for administration (Resident #1, #2, #3 and #4). Findings include: Employee #1 acknowledged that Resident #1, #2, #3 and #4 missed the administration of some of their medications in June and July 2010. Employee #1 added, "These residents received their medications from a mail order pharmacy and sometimes the refills did not arrive on time." Review of Resident #4's medication administration record (MAR) revealed Glyburide 2.5 mg was not administered from 6/20/20 to 7/12/20. The MAR also indicated Lisinopril 20 mg 1 tablet per day, was not administered to Resident #4 from 6/2/10 to 6/13/10 and on 7/14/10. - Average blood glucose during the time Resident #1 received his medication from 6/1/10 to 6/19/10 was 99.8 mg/dl. - Average blood glucose during the time Resident #1 failed to receive his medication from 6/20/20 to 7/12/10 was 142.5 mg/dl. - The blood glucose dropped from 168 mg/dl on 7/12/10 to 125 mg/dl on 7/13/10 and 127 mg/dl on 7/14/10 when Resident #4 received his Glyburide on those days. Employee #3 stated Resident #4 blood sugar levels had increased when he was out of his	Y 878	**1.Resident #4 received his medication on 7/13/10 as per Exhibit "B"; while exhibits "C"& "D" show their dispensation and his glucose readings.** **Resident # 3 received her medication on 7/15/10 as per exhibit # 3; while resident # 2 received his medications on 7/13/10 as per exhinit # F and dispensed per exhibit # G; Resident #1 received her multivitamin on 7/23/10 and continues to receive her medication as per exhibits H & I..** **2. The CIC has been given strict order to put more attention to medication Management and that there should be no recurrence of the "July" incidents. The rest of the staff are likewise enjoined to be very conscious and alert to this issue.** **3. The Administrator will put more attention on this matter and will be responsible for its compliance.** **4. Sept. 1, 2010**	

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Y 878	Continued From page 2 Glyburide. Review of Resident #3's MAR indicated Zolpidem Tartrate 10 mg 1 tablet daily was not administered from 7/1/10 to 7/14/10. Employee #3, on 7/14/10, reported Resident #3 was not sleeping well when her Zolpidem Tartrate (Ambien) was not administered. Employee #3 added, "With the medication she sleeps all night, without the medication she gets up several times during the night, but stays in her room." Resident #3 stated she did not know of any medications she was taking or any she had missed. Resident #3 stated she slept all night. Resident #3 appeared confused and had difficulty answering questions. Review of Resident #2's MAR indicated Omeprazole 20 milligrams (mg) 1 capsule daily was not administered from 7/9/10 to 7/14/10. Galanthamine Hydrochlorothiazide, 1 capsule daily was not administered from 7/9/10 to 7/14/10. Thiamine HCL 1 mg 1 tablet daily was not administered from 7/3/10 to 7/14/10. Pravastatin 40 mg 1 tablet daily was not administered from 7/1/10 to 7/14/10. Employee #1 commented that Resident #2 had no ill effects of not receiving his medications. Resident #2 stated he did not know what medications he was taking, but he felt okay and he had been fine for the past 2 weeks. Resident #2, date of birth 3/30/50, was younger than the other residents in the facility and appeared stable. Employee #3 concurred with this assessment. Review of the Resident #1's June 2010 MAR revealed Multivitamin-Tab-A Vit. 1 tablet daily, was not administered from 6/1/10 to 6/30/10. Employee #1 acknowledged Resident #1 failed to receive her multivitamin medication during the month of June 2010. Employee #3 reported Resident #1 had no ill effects for this missed	Y 878		

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Y 878	Continued From page 3 medication. Severity: 3 Scope: 3	Y 878		